MINNESOTA LIFE

NOTICE OF DEATH

Group Division Claims • P.O. Box 64114 • St. Paul, Minnesota 55164-0144 • FOR CLAIM INFO CALL: Toll Free **1-800-328-9442** – MN local **651- 665-3815**

ADMINISTRATOR'S STATEMENT: Complete Parts 1,2 and 4 if employee dies. Complete Parts 1,3 and 4 if dependent dies. Attach a certified copy of the official death record or have the attending physician complete the Physician's Statement on the reverse side of this form.

PART 1 - EMPLOYEE INFORMATION

1. EMPLOYER/POLICYHOLDER NAME	2. BRANCH LOCATION/UNIT NUMBER (If Applicable)	3. PLAN/POLICY NUMBER
4. EMPLOYEE LAST NAME	5. EMPLOYEE FIRST NAME	6. EMPLOYEE MIDDLE NAME
7. EMPLOYEE ADDRESS (Street, City, State, Zip)		
8. EMPLOYEE SOCIAL SECURITY NUMBER	9. EMPLOYEE DATE OF BIRTH	10. EMPLOYEE TELEPHONE NUMBER
11. EMPLOYEE DATE OF HIRE	12. EFFECTIVE DATE OF EMPLOYEE'S INSURANCE	13. EMPLOYEE ACTIVELY AT WORK ON EFFECTIVE DATE? ☐ YES ☐ NO

PART 2 - DECEASED EMPLOYEE (If enrollment cards are maintained in your office, attach a photo of the employee's card.)

WITHOUT A COMPLETED IRS FORM W-9 BY THE BENEFICIARY, THE BENEFICIARY MAY BE SUBJECT TO GOVERNMENT IMPOSED BACKUP WITHHOLDING ON INTEREST PAID.

1. LAST DATE DECEASED WAS ACTIVELY AT WORK PERFORMING NORMAL DUTIES (Mo/Day/Yr)	2. REASON DECEASED STOPPED ACTIVELY WORKING	3. DATE OF DEATH (Mo/Day/Yr)
4. DATE EMPLOYER'S UNIT ENTERED GROUP INSURANCE PLAN (Mo/Day/Yr)	5. DATE TO WHICH PREMIUMS WERE PAID FOR DECEASED (Mo/Day/Yr)	

6. BENEFICIARY AS RECORDED ON RECORDS OF EMPLOYER	ADDRESS (Street, City, State, Zip) AND DAYTIME TELEPHONE NUMBER OF BENEFICIARY	RELATIONSHIP TO EMPLOYEE	BENEFICIARY'S SOCIAL SECURITY NUMBER	BENEFICIARY'S AGE
a.				
b.				
c.				

7. AMOUNT OF INSURANCE (If based on salary, complete salary information) $	8. SALARY ON DATE LAST WORKED $	9. EFFECTIVE DATE OF THAT SALARY

PART 3 - DECEASED DEPENDENT (If enrollment cards are maintained in your office, attach a photo of the employee's card.)

WITHOUT A COMPLETED IRS FORM W-9 BY THE EMPLOYEE, THE EMPLOYEE MAY BE SUBJECT TO GOVERNMENT IMPOSED BACKUP WITHHOLDING ON INTEREST PAID.

*1. DECEASED DEPENDENT'S SOCIAL SECURITY NUMBER	2. IS EMPLOYEE STILL ACTIVELY WORKING ☐ Yes ☐ No	3. MARITAL STATUS OF DEPENDENT ☐ Single ☐ Divorced ☐ Married ☐ Widowed
4. NAME OF INSURED DEPENDENT	5. RELATIONSHIP TO EMPLOYEE	

6. DURATION OF FINAL ILLNESS OR DATE DEPENDENT BECAME CONFINED TO HOSPITAL OR HOME	7. DATE OF BIRTH OF DEPENDENT (Mo/Day/Yr)	8. DATE OF DEATH OF DEPENDENT (Mo/Day/Yr)
9. EFFECTIVE DATE (Mo/Day/Yr) OF DEPENDENTS INSURANCE	10. DATE PREMIUMS (Mo/Day/Yr) FOR DEPENDENTS COVERAGE PAID TO	11. AMOUNT OF INSURANCE $

PART 4 - CERTIFICATION I certify that on the date of death, the above named was insured under this policy. I further certify that the information provided above is true and correct to the best of my knowledge and belief.

1. NAME OF EMPLOYER, ASSOCIATION OR FUND	2. TELEPHONE NUMBER ( )
3. ADDRESS OF EMPLOYER, ASSOCIATION OR FUND (Street, City, State, Zip)	

4. SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE SIGNED	TITLE
X		

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against the insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. The commission of insurance fraud may subject such person to criminal and/or civil penalties. Any insurance company or agent of an insurance company who knowingly attempts to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance.

PHYSICIAN'S STATEMENT

1. Full Name of Deceased

Residence at Death

Date of Death Age at Death

Place of Death

(If hospital or institution, give name)

2. Cause of Death

Enter only one cause per line for (A), (B) and (C).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

Disease or Condition Directly Leading to Death*

(A) _____

Antecedent Causes
Morbid conditions, if any giving rise to the above cause (A) stating the underlying cause last.

Due to (B) _____

Due to (C) _____

Interval between Onset and Death

(A) _____

(B) _____

(C) _____

Other Significant Conditions
Conditions contributing to the death but not related to the disease or condition causing death.

3. Date of First Attendance in Last Illness

Date of Last Attendance in Last Illness

4. If Death was due to accident, suicide, or homicide, specify which. Describe Briefly.

Was an inquest held? ☐ Yes ☐ No

Was an autopsy performed? ☐ Yes ☐ No
If so, by whom and with what findings?

5. Have you treated or advised the deceased during the last 5 years prior to the last illness? ☐ Yes ☐ No

Did the deceased, to your knowledge, receive treatment during the last 5 years from any other physician, or in any hospital or institution? ☐ Yes ☐ No

If yes to either question, please furnish the following:

NAME	ADDRESS	NATURE OF ILLNESS OR INJURY	DATES

These statements are true and complete to the best of my knowledge and belief.

_____ M.D.
(Signature)

_____ , _____
(Date)

_____
(Address)

A graduate of _____ Year _____

To the physician:
Please conform as closely as possible to the International List of Causes of Death. If the case falls in the class of violent or accidental death, please give details and describe how injury was received. If suicide or homicide, state the means employed. In surgical cases, state the nature of the operation and of the disease or condition which required such procedure. In females, puerperal states are to be indicated, if involved. In neoplasms, give type and part first involved. Please avoid indefinite terms. Describe any unusual features and amplify sufficiently to make the case clear.